		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.

IDPH Facility ID Number: 0014506

Facility Name: The United Methodist Village

Address: 1616 Cedar Street (Number) Lawrenceville (City) 62349 (Zip Code)

County: Lawrence

Telephone Number: (618) 943-3347 **Fax #** (618) 943-3823

IDPA ID Number: 37-0673519001

Date of Initial License for Current Owners: 01/01/25

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: John Knoblett **Telephone Number:** (618) 943-3344

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Jerry Akin

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) John S. Knoblett, Member

(Firm Name & Address) Kemper CPA Group LLC
1100 Lexington Ave., Lawrenceville, IL 62439

(Telephone) (618) 943-3344 Fax # (618) 943-2368

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	165	Skilled (SNF)	165	60,390	1
2		Skilled Pediatric (SNF/PED)			2
3	42	Intermediate (ICF)	42	15,372	3
4		Intermediate/DD			4
5	80	Sheltered Care (SC)	80	29,280	5
6		ICF/DD 16 or Less			6
7	287	TOTALS	287	105,042	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	28,486	16,885	2,865	48,236	8
9	SNF/PED					9
10	ICF	3,598	6,659		10,257	10
11	ICF/DD					11
12	SC	3,893	10,976		14,869	12
13	DD 16 OR LESS					13
14	TOTALS	35,977	34,520	2,865	73,362	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.84%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/01/25

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,865

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 01/01/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	358,641	25,054	13,600	397,295		397,295	(13,445)	383,850			1
2	Food Purchase		308,400		308,400		308,400		308,400			2
3	Housekeeping	236,349	37,958	3,227	277,534		277,534	(13,619)	263,915			3
4	Laundry	116,686	36,450	310	153,446		153,446		153,446			4
5	Heat and Other Utilities			465,417	465,417		465,417	(119,975)	345,442			5
6	Maintenance	188,128	102,355	38,436	328,919	(8,855)	320,064	(21,691)	298,373			6
7	Other (specify):*											7
8	TOTAL General Services	899,804	510,217	520,990	1,931,011	(8,855)	1,922,156	(168,730)	1,753,426			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	2,067,602	91,431	4,938	2,163,971		2,163,971		2,163,971			10
10a	Therapy	68,978	770	85,980	155,728		155,728		155,728			10a
11	Activities	113,993	3,960	5,030	122,983		122,983		122,983			11
12	Social Services	75,369	10	(7,559)	67,820	8,855	76,675		76,675			12
13	Nurse Aide Training											13
14	Program Transportation					389	389		389			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,325,942	96,171	96,189	2,518,302	9,244	2,527,546		2,527,546			16
	C. General Administration											
17	Administrative	49,447	510	5,400	55,357		55,357	(5,484)	49,873			17
18	Directors Fees											18
19	Professional Services			97,927	97,927		97,927	(19,944)	77,983			19
20	Dues, Fees, Subscriptions & Promotions			50,065	50,065		50,065	(27,985)	22,080			20
21	Clerical & General Office Expenses	332,311	28,306	84,855	445,472		445,472	(25,825)	419,647			21
22	Employee Benefits & Payroll Taxes			578,995	578,995	75,776	654,771	(11,826)	642,945			22
23	Inservice Training & Education			4,824	4,824	(2,812)	2,012		2,012			23
24	Travel and Seminar					2,423	2,423		2,423			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			105,946	105,946	(53,850)	52,096		52,096			26
27	Other (specify):* Childcare	120,609		(98,683)	21,926	(21,926)						27
28	TOTAL General Administration	502,367	28,816	829,329	1,360,512	(389)	1,360,123	(91,064)	1,269,059			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,728,113	635,204	1,446,508	5,809,825		5,809,825	(259,794)	5,550,031			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The United Methodist Village #0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			662,884	662,884		662,884	(171,308)	491,576			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,250	58,250		58,250	(58,250)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			721,134	721,134		721,134	(229,558)	491,576			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,309	800	90,109		90,109		90,109			39
40	Barber and Beauty Shops			31,521	31,521		31,521		31,521			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,216	112,216		112,216		112,216			42
43	Other (specify):* See attached			83,085	83,085		83,085	(83,085)				43
44	**TOTAL Special Cost Centers**		89,309	227,622	316,931		316,931	(83,085)	233,846			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,728,113	724,513	2,395,264	6,847,890		6,847,890	(572,437)	6,275,453			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(18,478)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(58,250)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(738)	22		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(19,944)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(475,027)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (572,437)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (572,437)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The United Methodist Village

ID# 0014506

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Advertising	$ (27,985)	20	1
2	Gift planning	(1,110)	21	2
3	Gift planning	(13,835)	21	3
4	Interest expense	(3,332)	21	4
5	Medical insurance premium	(61,747)	43	5
6	Hospital expense	(18,060)	43	6
7	Resident services	(3,236)	43	7
8	Independent Living:			8
9	Housekeeping	(13,619)	3	9
10	Utilities	(101,497)	5	10
11	Maintenance	(21,691)	6	11
12	Administrative	(5,484)	17	12
13	Clerical	(7,548)	21	13
14	Employee Benefits	(11,088)	22	14
15	Depreciation	(171,308)	30	15
16	Miscellaneous	(42)	43	16
17	Dietary	(13,445)	1	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
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71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(475,027)		90

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number The United Methodist Village **#** 0014506 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(13,445)	0	0	0	0	0	0	0	0	0	0	(13,445)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(13,619)	0	0	0	0	0	0	0	0	0	0	(13,619)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(119,975)	0	0	0	0	0	0	0	0	0	0	(119,975)	5
6	Maintenance	(21,691)	0	0	0	0	0	0	0	0	0	0	(21,691)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(168,730)	0	0	0	0	0	0	0	0	0	0	(168,730)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(5,484)	0	0	0	0	0	0	0	0	0	0	(5,484)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(19,944)	0	0	0	0	0	0	0	0	0	0	(19,944)	19
20	Fees, Subscriptions & Promotions	(27,985)	0	0	0	0	0	0	0	0	0	0	(27,985)	20
21	Clerical & General Office Expenses	(25,825)	0	0	0	0	0	0	0	0	0	0	(25,825)	21
22	Employee Benefits & Payroll Taxes	(11,826)	0	0	0	0	0	0	0	0	0	0	(11,826)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(91,064)	0	0	0	0	0	0	0	0	0	0	(91,064)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(259,794)	0	0	0	0	0	0	0	0	0	0	(259,794)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number The United Methodist Village **#** 0014506 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(171,308)	0	0	0	0	0	0	0	0	0	0	(171,308)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(58,250)	0	0	0	0	0	0	0	0	0	0	(58,250)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(229,558)	0	0	0	0	0	0	0	0	0	0	(229,558)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(83,085)	0	0	0	0	0	0	0	0	0	0	(83,085)	43
44	**TOTAL Special Cost Centers**	(83,085)	0	0	0	0	0	0	0	0	0	0	(83,085)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(572,437)	0	0	0	0	0	0	0	0	0	0	(572,437)	45

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	McKiou Center		X	Provide future living	$225,000/annual	01/20/95	2,225,000	765,000	12/01/03	Various	58,250	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 2,225,000	$ 765,000			$ 58,250	14
15	TOTALS (line 9+line14)						$ 2,225,000	$ 765,000			$ 58,250	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	N/A	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	N/A	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	N/A	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	N/A	8
	1996	N/A	9
	1997	N/A	10
	1998	N/A	11
	1999	N/A	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,538 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	631,620	1924	$ 96,018	1
2	Land	572,380	1987/1989	63,690	2
3	TOTALS	1,204,000		$ 159,708	3

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1965		$ 1,350,000	$ 27,000	50	$ 27,000	$	$ 945,000	4
5	128		1967		1,177,857	23,557	50	23,557		787,872	5
6	50		1974		916,911	18,338	50	18,338		596,065	6
7	Old Holden										7
8	Center				225,443					225,443	8
	Improvement Type**										
9	Wesley building remodeling				792,043	15,252	15-50	15,252		725,608	9
10	Dycus building remodeling			1980	40,364	1,487	20-50	1,487		30,490	10
11	Wesley I & Wesley II remodeling			1981	60,556	3,028	20	3,028		59,043	11
12	Wesley I & Wesley II remodeling			1982	106,354		10			106,354	12
13	Wesley I & Wesley II remodeling			1983	143,511		5-10			143,511	13
14	Wesley I & Wesley II remodeling			1984	82,405		5-10			82,405	14
15	Landscaping, sewer, roofing			1985	233,556	6,705	5-15	6,705		230,537	15
16	Landscaping, kitchen, nurse's station, garage			1986	49,146	2,966	5-15	2,966		47,644	16
17	Driveway, gift shop, dining room roof, heat exchanger,										17
18	garage			1987	75,506	4,019	10-15	4,019		69,476	18
19	Landscaping, remodel bathroom, roof, laundry room			1988	159,843	10,732	10-25	10,732		139,587	19
20	Parking lot, beauty shop, shower room, accounting										20
21	office, computer room			1989	131,028	4,947	4-40	4,947		75,189	21
22	Landscaping, heat exchangers, elevator doors, Auten										22
23	Center			1990	886,389	40,644	5-40	40,644		440,772	23
24	Parking lot, carpeting, electrical, ceiling, windows,										24
25	plumbing, gazebo			1991	189,373	8,938	5-30	8,938		109,770	25
26	Decks, asphalt, roofing, sprinklers, windows, chairs,										26
27	dining room			1992	434,747	24,462	5-25	24,462		213,674	27
28	Gazebo, parking lot, wallpaper, blinds, electrical,										28
29	pole barn			1993	281,258	20,456	5-20	20,456		174,624	29
30	Parking lot, carpeting, windows, plumbing, heating			1994	79,040	5,846	5-20	5,846		37,999	30
31	Boiler, carpeting, fixtures, electrical, plumbing,										31
32	paint handrails			1995	241,445	23,152	5-20	23,152		127,356	32
33	Boiler, carpeting, doors, elevators, roof, windows,										33
34	paint			1996	287,583	22,954	5-20	22,954		103,293	34
35											35
36	TOTAL (lines 4 thru 35)				$ 7,944,358	$ 264,483		$ 264,483	$	$ 5,471,712	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking lot, paint, carpeting, electrical, roof, air handler,										9
10	door closers, parts, aircoil & venting, plywood & materials,										10
11	remodeling, microwave			1997	132,407	15,390	5-20	15,390		53,867	11
12	Chapel renovation			1998	11,404	1,140	10	1,140		2,850	12
13	Roof			1998	3,020	302	10	302		755	13
14	Room remodeling			1998	3,055	611	5	611		1,528	14
15	Boiler enhancement			1998	1,174	234	5	234		585	15
16	Remodel nurse's station			1998	3,701	528	7	528		1,320	16
17	Water heating			1998	4,163	278	15	278		695	17
18	Nurse's station sink			1998	844	42	20	42		105	18
19	Remodel hallway			1998	20,380	4,076	5	4,076		10,190	19
20	Remodel Holden			1999	7,509	1,220	5-20	1,220		1,830	20
21	Remodel Dycus			1999	1,225	122	10	122		183	21
22	Remodel Wesley I & II-HVAC & Roof			1999	330,944	33,094	10	33,094		44,746	22
23	Remodel Dycus-carpeting, water & A/C heaters, plumbing			2000	95,918	2,673	5-20	2,673		2,673	23
24	Remodel Holden-A/C and roof			2000	17,352	424	7-10	424		424	24
25	Remodel Wesley-boiler upgrade, carpeting, electric door locks			2000	14,491	284	5-20	284		284	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 647,587	$ 60,418		$ 60,418	$ 0	$ 122,035	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

0 Page 12A
0 Page 12B
0 Page 12C
0 Page 12D

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,036,241	$ 136,640	$ 136,640	$	4-10	$ 725,159	37
38	Current Year Purchases	42,882	5,507	5,507		5-10	5,507	38
39	Fully Depreciated Assets	1,634,764	6,588	6,588		3-20	1,634,734	39
40								40
41	TOTALS	$ 2,713,887	$ 148,735	$ 148,735	$		$ 2,365,400	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport	Various	Various	$ 165,238	$ 9,224	$ 9,224	$	3 to 10	$ 162,146	42
43	Patient Transport	1991 Chevy Caprice	1997	8,854	1,731	1,731		4	6,060	43
44	Patient Transport	1999 Buick Park Ave	1999	17,426	3,485	3,485		5	5,228	44
45	Patient Transport	Van	1999	14,000	3,500	3,500		4	4,667	45
46	TOTALS			$ 205,518	$ 17,940	$ 17,940	$		$ 178,101	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 11,671,058	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 491,576	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 491,576	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 8,137,248	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apts & Cottages-Buildings	$ 1,768,427	$ 60,665	$ 934,243	52
53	Apts & Cottages-Furnishings	311,783	13,674	248,887	53
54	Apts & Cottages-2000 Furnishings	14,341	1,123	1,123	54
55	McKiou Center	3,430,075	95,846	693,589	55
56					56
57	TOTALS	$ 5,524,626	$ 171,308	$ 1,877,842	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	709	$ 32,497	$	709	$ 32,497	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		202	9,100		202	9,100	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,126	44,383		2,126	44,383	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			800			800	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				70,775		70,775	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39-2					18,534		18,534	13
14	TOTAL			$	3,037	$ 86,780	$ 89,309	3,037	$ 176,089	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number The United Methodist Village # 0014506 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 102,547	$	1
2	Cash-Patient Deposits	59,953		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,435)	931,063		3
4	Supply Inventory (priced at)	28,488		4
5	Short-Term Investments	6,737		5
6	Prepaid Insurance	263		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	495,354		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,624,405	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	159,708		13
14	Buildings, at Historical Cost	13,512,588		14
15	Leasehold Improvements, at Historical Cost	310,258		15
16	Equipment, at Historical Cost	3,213,130		16
17	Accumulated Depreciation (book methods)	(9,356,405)		17
18	Deferred Charges	6,787		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	157,541		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investments	5,143,575		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,147,182	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,771,587	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 478,747	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	364,974		29
30	Accrued Salaries Payable	75,769		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached schedule	531,552		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,451,042	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	480,443		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached schedule	1,788,479		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,268,922	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,719,964	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,051,623	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,771,587	$	48

***(See instructions.)**

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,202,302	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,202,302	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(150,679)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (150,679)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,051,623	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,930,785	1
2	Discounts and Allowances for all Levels	(1,108,183)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,822,602	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	272,179	6
7	Oxygen	7,717	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 279,896	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	41,991	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	46,165	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	79,156	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 167,312	23
	D. Non-Operating Revenue		
24	Contributions	396,009	24
25	Interest and Other Investment Income***	30,392	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 426,401	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on sale of fixed assets	1,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,697,211	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,931,011	31
32	Health Care	2,518,302	32
33	General Administration	1,360,512	33
	B. Capital Expense		
34	Ownership	721,134	34
	C. Ancillary Expense		
35	Special Cost Centers	204,715	35
36	Provider Participation Fee	112,216	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,847,890	40
41	**Income before Income Taxes (line 30 minus line 40)****	(150,679)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (150,679)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,080	$ 44,202	$ 21.25	1
2	Assistant Director of Nursing	2,016	2,130	40,213	18.88	2
3	Registered Nurses	24,091	25,549	387,007	15.15	3
4	Licensed Practical Nurses	26,683	27,686	377,779	13.65	4
5	Nurse Aides & Orderlies	118,229	124,685	1,071,950	8.60	5
6	Nurse Aide Trainees	13,266	13,593	76,561	5.63	6
7	Licensed Therapist	177	177	6,324	35.73	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,189	29,213	13.35	9
10	Activity Assistants	10,721	11,574	73,128	6.32	10
11	Social Service Workers	7,547	7,984	63,889	8.00	11
12	Dietician	1,092	1,115	6,149	5.51	12
13	Food Service Supervisor	1,872	2,141	29,557	13.81	13
14	Head Cook	1,752	1,923	13,499	7.02	14
15	Cook Helpers/Assistants	40,342	42,121	269,930	6.41	15
16	Dishwashers	4,910	5,068	28,446	5.61	16
17	Maintenance Workers	16,782	17,487	193,176	11.05	17
18	Housekeepers	38,524	40,306	257,202	6.38	18
19	Laundry	12,012	13,152	99,760	7.59	19
20	Administrator	4,368	4,968	122,270	24.61	20
21	Assistant Administrator					21
22	Other Administrative	6,570	6,981	91,497	13.11	22
23	Office Manager	1,984	2,080	38,644	18.58	23
24	Clerical	16,137	16,977	142,638	8.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	17,745	18,974	134,339	7.08	31
32	Other Health Care(specify)					32
33	Other(specify) See attached	19,192	19,843	130,740	6.59	33
34	TOTAL (lines 1 - 33)	389,996	410,783	$ 3,728,113 *	$ 9.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	228	$ 11,346	1-3	35
36	Medical Director	96	7,800	9-3	36
37	Medical Records Consultant	21	1,320	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,236	11-3	44
45	Social Service Consultant	22	1,274	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	388	$ 22,976		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Billie Taylor	Administrator	0%	$ 13,689
Paul Fiscus	Administrator	0%	16,286
Jerry Akin	Administrator	0%	19,472
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 49,447

B. Administrative - Other

Description	Amount
Dowain Mckiou-Corporate Executive Director Salary	$ 5,400
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 5,400

C. Professional Services

Vendor/Payee	Type	Amount
Kemper CPA Group LLC	Audit & Tax Returns	$ 13,650
Kemper CPA Group LLC	Costs Reports	2,000
Kemper CPA Group LLC	Acct. Asst/Payroll Prep.	13,160
Robert Lumbrix	Accounting Fees	6,000
Answers on Demand, Inc.	Accounting Assistance	392
Stout & Holtzhouser	Legal	393
Stobbs & Sinclair	Legal	361
Fine & Hatfield	Legal	300
McDermott, Will & Emery	Legal	37,602
Lewis, Rice & Fingerish L.C.	Legal	19,944
John Nolan	Legal	4,125
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 97,927

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,850
Unemployment Compensation Insurance	37,152
FICA Taxes	272,291
Employee Health Insurance	238,492
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	31,060
Childcare	21,926
Less:	
Payroll Penalty	(738)
Independent Living portion	(11,088)
TOTAL (agree to Schedule V, line 22, col.8)	$ 642,945

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,258
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	1,379
Advertising & promotion	27,985
Licenses, taxes & fees	5,443
Less: Public Relations Expense	( )
Non-allowable advertising	(27,985)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,080

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	235
Seminar Expense	2,577
Less: 5% Travel adjustment	(389)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,423

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **112,216**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Kemper CPA Group LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

THE UNITED METHODIST VILLAGE, INC.

#0014506 1/1/00 - 12/31/00

SCHEDULE V

Line 43 - Other Costs:

	Salary	Supplies	Other	Total
Resident services			$ 3,236	$ 3,236
Hospital expense - residents			18,059	18,059
Insurance expense - residents			61,748	61,748
Independent living			42	42
Total Other Costs	$ -	$ -	$ 83,085	$ 83,085

THE UNITED METHODIST VILLAGE, INC.

#0014506 1/1/00 - 12/31/00

SCHEDULE V

Reclassifications:	Line	Increase	Decrease
Reclassify Program Transportation:			
Program Transportation	14	$ 389	
Travel & Seminar	24		$ 389
Reclassify Child Care Benefits:			
Employee Benefits	22	21,926	
Other Child Care	27		21,926
Reclassify Transportation Recovery:			
Social Services	12	8,855	
Maintenance	6		8,855
Reclassify Travel & Semninar Expense:			
Travel & Seminar	24	2,812	
Education - Other	23		2,812
Reclassify Workers' Compensation Insurance Expense:			
Employee Benefits	22	53,850	
Ins.-Prep. Liab. Malpractice	26		53,850

THE UNITED METHODIST VILLAGE, INC.

#0014506 1/1/00 - 12/31/00

Schedule XV. BALANCE SHEET

Line 36 - Other Current Liabilities:

Advance Resident Billings	269,370
Resident Trust Funds	59,953
Accrued Liabilities	202,229
Other Current Liabilities	531,552

Line 43 - Other Long-Term Liabilities:

Annuity Obligations	223,315
Deferred Revenue from Entrance Fee	1,138,222
Obligation for Future Services	426,942
Other Long-Term Liabilities	1,788,479

THE UNITED METHODIST VILLAGE, INC.

#0014506 1/1/00 - 12/31/00

Schedule XVII. INCOME STATEMENT

Line 21 - Other Medical Services:

Guest Room Rental	1,125
Resident Purchases	2,409
Utility	75,622
Other Medical Services	79,156

THE UNITED METHODIST VILLAGE, INC.

#0014506 1/1/00 - 12/31/00

SCHEDULE XVIII. A. STAFFING AND SALARY COSTS

Line 33 - Other:

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Volunteers	735	776	5,000	6.44
Chaplain	510	510	10,250	20.10
Child Care	17,907	18,502	115,175	6.23
Independent Living	40	55	315	5.73
Total Other	19,192	19,843	$ 130,740	6.59

THE UNITED METHODIST VILLAGE, INC.

#0014506 1/1/00 - 12/31/00

SCHEDULE XI - OWNERSHIP COSTS

Line 51 - Accumulated Depreciation:

The accumulated depreciation differs from the balance sheet by $658,685 because accelerated depreciation has been claimed in prior years as Medicaid Cost.

We have discontinued this practice and are using only the straight line method.

Cost Report	$10,015,090
G/L Accum. Deprec.	9,356,405
	$ 658,685

SCHEDULE XX - GENERAL INFORMATION

Line 14:

A small portion of the building is used for adult day care. Cost is unknown, therefore, revenue was offset against costs.